ALCOHOL AND/OR CONTROLLED SUBSTANCE TEST NOTIFICATION

State Department of :_____

Employee/Applicant Name (Print First, M.I. Last): _____

You are hereby notified of the requirement to test pursuant to the Drug and Alcohol Testing Agreement of: BU ___; ☐ CDL ☐ HGEA ☐ UPW ☐ HRS 78-2.6.

Cost of test paid by: ☐ applicant ☐ employee ☐ department

1. The test is scheduled: **Date:** _____
   Location: _____
   Appointment Time: _____

2. Test for: ☐ Alcohol ☐ Controlled Substance

3. Type of test: ☐ Pre-Employment (Post-Offer) ☐ Prior to Recruit Training
   ☐ Post Recruit or Prior to Assigned Workplace ☐ Probationary
   ☐ Random ☐ Return to Duty ☐ Follow-up
   ☐ Post-Accident ☐ Post-Altercation ☐ Reasonable Suspicion

4. Employee/Applicant has picture identification card: ☐ Yes ☐ No

5. Transportation to test site or appointment instructions/comments:

   _____

   _____

6. Time of notification: _____ a.m. p.m.

I understand that the identified test is required and if I refuse to sign this form or refuse to take the tests identified, I am subject to consequences as stated in the Agreement. Applicants who refuse to sign are removed from the list of eligibles.

_____ _____
Employee/Applicant Signature Date

_____ _____
Department Representative Date

RETAIN IN EMPLOYEE'S CONFIDENTIAL FILE